KANSAS ENDOSCOPY

Office Use Only

Patient Name _____

ID#:_____Physician #:_____Date: _____

Financial Policy

The following is a statement of our Financial Policy which we request that you read and sign as your acknowledgement and understanding. Kansas Endoscopy, LLC (KSE) is committed to providing quality care for our patients. Our charges are considered to be usual and customary for our area.

Co-pays/Coinsurance/Deductibles

We must receive your copay, coinsurance, and/or deductible two weeks prior to your scheduled procedure. If your procedure is scheduled with fewer than two weeks' notice, payment is due immediately. We accept cash, check, Visa, or Mastercard. If payment is not received in full two weeks before the procedure date, the procedure will be cancelled and rescheduled once full payment is received.

Insurance

As a courtesy to our patients, we will file your Primary and Secondary insurance that you provide at the time of your arrival. In order to properly bill your insurance company, we require that you disclose all necessary information required to file your insurance. This includes any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the services. Although we may estimate the payment from your insurance company, it is the insurance company that determines the final payment based on your eligibility and benefits.

Should you not have insurance coverage, you will be responsible for paying your balance in full at the time the services are rendered.

Referrals and Pre-authorizations

You are responsible for obtaining a referral and/or preauthorization from your insurance company should it be required for any services you may receive at KSE or from any of their providers. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company. By signing below, you understand that the amount of the services will become your responsibility.

Cancellations or Missed Appointments

We require 24-hour notice for appointment cancellations. **Appointments scheduled for a procedure at Kansas Endoscopy may be charged a fee of $100.00 if missed or not previously cancelled within 24 hours of the scheduled procedure.**

By signing below, you understand this financial policy including your responsibility for timely payment of the account. You will receive a statement for services which are due and payable upon receipt. KSG accepts cash, check, Visa, MasterCard and Discover. If timely payment is not received, the account may be sent to an outside collection agency or attorney. This may result in the unfortunate dismissal from the practice. If a check is returned from the bank due to insufficient funds, a $35.00 charge will be applied to your account. You may be placed on a cash only basis following any returned check.

<u>You may receive a billing statement from the following</u>:

1. Kansas Endoscopy (Facility Fee)
2. Physician who has provided your care
3. Anesthesia
4. Pathology or Lab

I have read the Financial Policy. I understand and agree to this policy.

X _____Date _____

Signature of Patient or Responsible Party

_____

Patient Name

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.